



TOOLKIT

*Clinical Considerations of
Antipsychotic Management*

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ABOUT THE CLINICAL CONSIDERATIONS OF ANTIPSYCHOTIC MANAGEMENT TOOLKIT

The Clinical Considerations of Antipsychotic Management Toolkit is a clinically-focused resource containing steps and objectives, expectations at each step, and offers or identifies tools and resources that will help you meet performance expectations and outcomes. It identifies the steps that need to be taken in order to clinically manage individuals who are taking antipsychotic medications, in attempting gradual dose-reduction, and to lower the off-label use of medications.

The model used for the toolkit framework is the Nursing Process, also referred to as the Care Delivery Process, with the addition of two steps. The Nursing Process steps include: recognition/assessment, diagnosis/clinical judgment, outcomes planning, implementation, and evaluation. The additional steps include: leadership and staff training. This model was chosen because it is one that nurses are familiar with, it is comprehensive and ongoing, and incorporates input from various disciplines. The model is a universally acknowledged method used to identify and address complex issues. It is consistent with standard problem-solving and quality improvement.

In keeping with recommended quality improvement approaches, the Leadership and Staff Training sections were added to the toolkit. Nursing center leaders/supervisors need to be invested and lead this quality improvement effort with input from all staff, residents, families and practitioners. This section of the framework details the support leadership must provide to ensure quality improvement success.

The Staff Training section was added to support the need for staff education in order to meet the center's quality expectations to safely lower antipsychotics.

This toolkit is designed to assist centers in moving toward a more appropriate decision-making process for antipsychotic medication use. However, it does not provide a comprehensive package of all aspects of care.

THE CLINICAL CONSIDERATIONS OF ANTIPSYCHOTIC MANAGEMENT FRAMEWORK

To access the tools or resources, click on the tool/resource name appearing in each section of the framework.

STEPS / OBJECTIVES	EXPECTATIONS	TOOLS / RESOURCES
<p>Leadership Set facility direction & goal to better manage antipsychotic drug use and individuals with dementia</p> <p>Ensure staff and others understand what needs to be done and how to accomplish the goal</p> <p>Provide staff education needed to achieve results (see Section of Staff Education)</p>	<ul style="list-style-type: none"> • Know your facility's antipsychotic prevalence rates (short & long-stay) by using CMS Quality Measures (QM) when available, AHCA and/or facility data • Set a facility antipsychotic quality measurement goal – focus on outcomes • Make sure all supervisors, staff and physicians are aware of and understand the goal • Make sure employees know their performance expectations • Hold employees accountable for following care process steps • Make regular employee rounds to address questions about the goal • Ensure all staff are trained on how to identify unmet needs and nurses are trained on recognizing common antipsychotics • Recognize departments and staff doing well in implementing process and using tools 	<p>Nursing Process Approach for Antipsychotic Drug – Gradual Dose Reduction</p> <p>Antipsychotic Prescription Log</p> <p>Sample Facility Policy for Use of Antipsychotic Medications</p> <p>Sample Antipsychotic Physician Memo</p> <p>LTC Trend Tracker: www.ltctrendtracker.com</p>
<p>Recognition/Assessment Timely identification of antipsychotic drug use and behavior, mood, cognition and function changes</p>	<ul style="list-style-type: none"> • Be able to recognize antipsychotic drugs commonly used in the LTC setting and the issues surrounding the use of these drugs • Observe resident behaviors • Describe behavior/symptom details like onset, intensity, duration, severity to self and/or others • Identify change in level of consciousness (e.g. alert, drowsy, stuporous, comatose) • Determine the necessity to control or limit behavior • Assess mood, thinking, function, and behavior within 24 hours of admission if an individual is taking an antipsychotic or identified as having a behavior problem • For individuals taking antipsychotics, identify where and why treatment started and how effective/problematic the treatment has been 	<p>INTERACT Care Path for Mental Status Change: www.INTERACT2.net</p> <p>Other Resources Individual's medical record, progress notes, hospital discharge summary, MAR, Stop and Watch Reports, and latest MDS assessment</p>

STEPS / OBJECTIVES	EXPECTATIONS	TOOLS / RESOURCES
<p>Diagnosis/Clinical Judgment Use existing medical information and assessment data to form an opinion about probable cause(s) of behavior/symptom</p> <p>Evaluate the current medical regimen as the potential source of behavior/symptom</p>	<ul style="list-style-type: none"> • Review assessment and observation data • Evaluate psychiatric reports • Contact family and/or others who may provide insight about behavior or add to medical history • Systematically determine if the behavior/symptom(s) are likely related to: <ul style="list-style-type: none"> ○ medical condition ○ use of an antipsychotic drug ○ the current medication regimen ○ psychosocial/unmet need ○ environmental cause 	<p>Approach to Considering Causes of Behavior Algorithm</p> <p>Guidance to Using the Behavioral Approach Algorithm</p> <p>INTERACT Change in Condition Cards: www.INTERACT2.net</p>
<p>Outcomes Planning Collect pertinent information as the basis for having identified a specific cause or causes of the problematic behavior/symptom</p>	<ul style="list-style-type: none"> • Contact your consultant pharmacist to identify/verify high risk medications most likely related to behavior/symptom • If antipsychotic drug use is likely part of the problem, consider discussing possible gradual dose reduction or drug discontinuance with the physician 	<p>Antipsychotic Medication Tapering Checklist</p>
<p>Implementation Organize and prepare assessment findings and information to be discussed with the physician</p> <p>Identify specific goals for managing the behavior/symptom</p> <p>After consultation with the physician, document the basis for having identified the problem/symptom(s) and basis for the cause of behavior/symptom</p>	<ul style="list-style-type: none"> • Collaborate with practitioners to identify possible urgent situations such as delirium or psychosis • Discuss your finding with the practitioner and work together to form a care plan and next steps • Discuss and document why causes were not sought or efforts to identify them were not fruitful • Implement/update care plan to address causes of behavior/system(s) • If indicated, develop a plan to taper or discontinue antipsychotic treatment • As much as possible, the plan should include non-pharmacological and behavior management strategies • Adapt or adjust the environment to minimize related causes • Include family in the plan development and approval of plan • Document in the medical record the basis for interventions 	<p>Antipsychotic SBAR</p> <p>What Is CHAT?</p> <p>Relevant CHATs</p> <p>Agitation CHAT</p> <p>Altered Mental Status CHAT</p> <p>Dizziness/Unsteadiness CHAT</p> <p>Fall CHAT</p>

STEPS / OBJECTIVES	EXPECTATIONS	TOOLS / RESOURCES
<p>Evaluation</p> <p>Monitor responses to interventions for each individual and adjust them accordingly</p> <p>Identify and address complications related to interventions</p> <p>Monitor facility frequency of antipsychotic drug use and the effectiveness of strategies</p>	<ul style="list-style-type: none"> • Monitor for care plan effectiveness • Review each resident's medication regimen for high risk medications and the appropriateness of continued use of any antipsychotic or other psychopharmacological medications • Form a Behavior Management Team to identify unmet needs and monitor and document the effectiveness of interventions 	<p>Antipsychotic Medication QA Review Tool</p> <p>Assessment of Resident Receiving Psychotropic Medication</p>
<p>Staff Education</p> <p>Ensure that staff have the knowledge and skills needed to appropriately provide care to individuals with behavior/symptom(s)</p>	<ul style="list-style-type: none"> • Instruct clinical staff on how to recognize and identify antipsychotic drugs commonly used in the LTC setting • Instruct clinical staff on how to apply a systematic approach to collecting, analyzing, documenting, and reporting medical information and clinical findings for potential cause for behavior/symptom • Educate all staff in identifying unmet needs 	<p>Antipsychotic Drugs Common Terms and Definitions</p> <p>Case Study 1: Behavior Issues in a Resident Who is Already Receiving Psychopharmacological Medications</p> <p>AHCA's Suggested Tools for Reducing Off Label Use of Antipsychotics: How These Tools Can Improve Regulatory Compliance</p> <p>University of Iowa – Improving Antipsychotic Appropriateness in Dementia Patients https://www.healthcare.uiowa.edu/igec/IAADAPT</p>

LEADERSHIP

USING THE NURSING PROCESS APPROACH TO CONSIDER GRADUAL DOSE REDUCTION (GDR)

Tapering For Off-Label Use of Antipsychotic Medications

The best approach to considering GDR is person-centered. Before contacting the individual's physician to discuss potential dose reduction, it is important for the nurse to follow the nursing process and gather observations and pertinent information. The nursing process uses clinical judgment to strike a balance between personal interpretation and research evidence. The process fosters the use of critical thinking to categorize clients issue and course of action. Below, the nursing process is applied to the nurse's role when considering the potential for GDR for off-label use of antipsychotic medication.

Nurse/Interdisciplinary Team Assessment

- Conduct an assessment and identify conditions possibly related to drug side-effect(s).
- Review most recent MDS assessment for mood, function, behavior, evidence of delirium and facility-based behavior tracking record. Compare to findings of the just completed assessment. Review most recent scoring tool (e.g., AIMS) and compare to prior score.
- Review medical record taking note of:
 - Psychiatric conditions, psychiatric hospitalizations, abnormal clinical and lab findings, and related physician, pharmacist, and psychologist notes.
 - Any GDR attempts during past 6 – 12 months and the outcome
- For individuals staying in the facility for longer periods of time:
 - Check the pharmacist's recommendations recorded on the monthly medication regimen review for information related to drug doses, duration and continued need.
- Review the CNA Stop and Watch reports for changes in behavior, cognition, mood, ADL performance, and daily routine. (Stop and Watch is an INTERACT II tool).

Diagnosis/Clinical Judgment

- Identify symptoms that may be related to antipsychotic medication side-effects.
 - e.g. orthostatic hypotension, increase weight gain, increase glucose level, urinary retention, constipation, sedation, akathisia (restlessness, pacing, inability to sit still, anxiety, sleep disturbance), dystonia/torticollis - stiffness of neck, pseudoparkinsonism (drooling, tremors, rigidity, bradykinesia - slowness of movement, cogwheel rigidity - jerk responses of body muscles when force is applied while bending a limb), tardive dyskinesia (lip smacking/chewing, abnormal tongue movement, involuntary movement of arms/legs), dry mouth, blurred vision, worsening confusion/delirium, edema, blood abnormalities (increased triglycerides)
 - Evaluate if symptoms are old or new
- Is the individual at optimal ADL function and quality of life?
- Will GDR/tapering possibly improve the individual's symptoms and functioning?

Outcomes/Planning

- Gather clinical information and diagnoses.
 - Include all medications currently taken by the individual, including:
 - Dosages and times of administration
 - Which of these medications may be contributing to issues and concerns?
- Gather information about drug considered for GDR
 - Current dose, time(s) of drug administration, and method of administration (tablets, capsules, liquid, injectable, IV).
 - How long has the individual been taking this drug?
 - Is the current drug dose at the lowest available dose? If so, does the dose provide the individual optimal quality of life and ADL functioning?
- Identify the non-pharmacological approaches used to help address challenging behavioral responses. Did these approaches work?
- Note assessment findings in the medical record.

Implementation

- Complete the SBAR designed for nurse consideration of antipsychotic medication GDR.
- If the individual is over-sedated:
 - Hold the drug until the physician is contacted.
 - A lower dose or a different medication may be used if behaviors or symptoms requiring antipsychotic treatment emerge.
- Attempt non-pharmaceutical approaches to help address challenging behavioral responses (examples include: music therapy, exercise).
- When possible, inform the individual and his/her family and care staff about the plan for GDR to gain their understanding and support.
- Call the physician to discuss possible medication discontinuance or tapering.

Evaluation

- Assess the individual's response to medication discontinuance or tapering.
- After one month, determine if the individual is at optimal ADL functioning and has an improved quality of life.
 - Repeat any clinical tests and labs ordered by the physician, and evaluate for improvement.
 - Evaluate the effectiveness of non-pharmaceutical approaches to challenging behavioral responses that have been employed, document and change if needed.
- Continue to evaluate and note medication reduction responses in the medical record. Notify the physician about further tapering or drug maintenance as necessary.

RECOMMENDED PHYSICIAN GUIDELINES FOR GDR

- Periodically review the progress of any resident receiving antipsychotic medications, including the frequency, duration, and intensity of any symptoms
- Review the resident's overall condition and symptoms, to identify anything else that may be impairing behavior or mood stability
- At any time, if it is uncertain whether a psychopharmacological medication (including antipsychotic medications) is making a difference, consider initiating a trial reduction (e.g., lower dose, lesser frequency of administration) to see the effects
- If behavior is worse or at least not stable within 72 hours of initiating a psychopharmacological medication (including antipsychotic medications), review the working diagnosis and treatment to see whether a change in treatment may be indicated.
- For an antipsychotic medication prescribed for an acute episode (for example: during a recent hospital stay), consider a trial dose reduction if the medication's effectiveness or the need for continued treatment is uncertain.
- If the drug is currently at the lowest dose, consider a different approach to dose reduction (e.g., fewer doses per day, treatment every other day).
- It is generally prudent to reduce doses gradually (over several days to several weeks), to be able to observe for effects of medication reduction and to allow the brain to adjust to changes in chemical balances.
- For individuals taking an antipsychotic drug for one year, attempt dose reduction in two separate quarters with at least one month apart unless the individual is at optimal functioning.
- After longer than one year of drug therapy, attempt drug reduction once per year. If GDR is unsuccessful after two or more attempts, further reduction may be "clinically contraindicated." Documentation is needed in the individual's record why additional dose reduction will cause impairment, psychiatric instability, or exacerbate the underlying psychiatric disorder.

RESOURCES

American Medical Directors Association. Delirium and Acute Problematic Behavior, Clinical Practice Guideline, 2008

American Nurses Association. The Nursing Process. <http://nursingworld.org/EspeciallyForYou/What-is-Nursing/Tools-You-Need/TheNursingProcess.html>

The Long Term Care Survey, F-TAG 329. AHCA October 2010 Edition, pp. 441-555

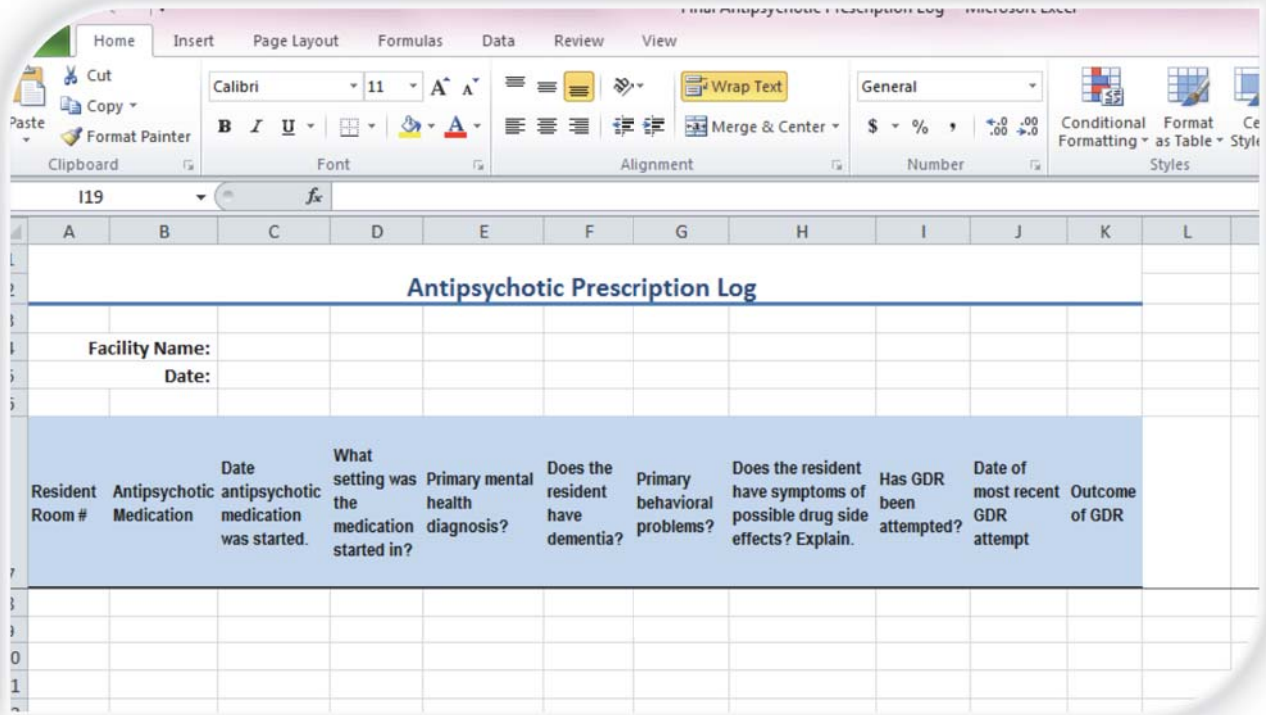
Power, AG. Dementia Beyond Drugs: Changing The Culture of Care. Health professions press, February 2010, pp. 237-238

Psychopharmacological Drugs Gradual Dose Reduction Schedule. Skilled Care Pharmacy 2009 - <http://www.skilledcare.com/Userfiles/Care-Letters/GRADUAL-DOSE-REDUCTION-SCHEDULE.pdf>

Ryan Carnahan, Phar.D., M.S., BCPP, Assistant Professor (Clinical), The University of Iowa College of Public Health, Recommendations offer to Dr. Gifford, February 27, 2012

ANTIPSYCHOTIC PRESCRIPTION LOG

Download this Excel tool to help keep track for antipsychotic medication use in your organization.



SAMPLE FACILITY POLICY FOR USE OF ANTIPSYCHOTIC MEDICATIONS

(Facility Name)_____ recognizes that antipsychotics benefit only some residents and can be associated with side effects and risks. Therefore, when antipsychotic medications are used in our facility, the facility will identify target behaviors and implement a care plan with both non-pharmacological and pharmacological interventions. Potential adverse drug reactions and side effects will also be evaluated along with a plan for periodic attempts at dose reduction, where indicated or unless clinically contraindicated.

SAMPLE FACILITY MEMO TO PHYSICIANS ON ANTIPSYCHOTIC MEDICATION USE

Date:

To: Facility Physicians
From: Facility Administrator / DON

Dear Doctors:

On May 30, 2012 Centers for Medicare and Medicaid (CMS) announced the Partnership to Improve Dementia Care, an initiative to ensure appropriate care and use of antipsychotic medications for nursing home patients. This partnership consists of federal and state entities, nursing homes and other providers, advocacy groups, and caregivers. The initiative was spurred by research showing that one quarter of Medicare beneficiaries in nursing homes are prescribed antipsychotic medications and that the use of these drugs may be beneficial but may also be associated with increased risk of death.

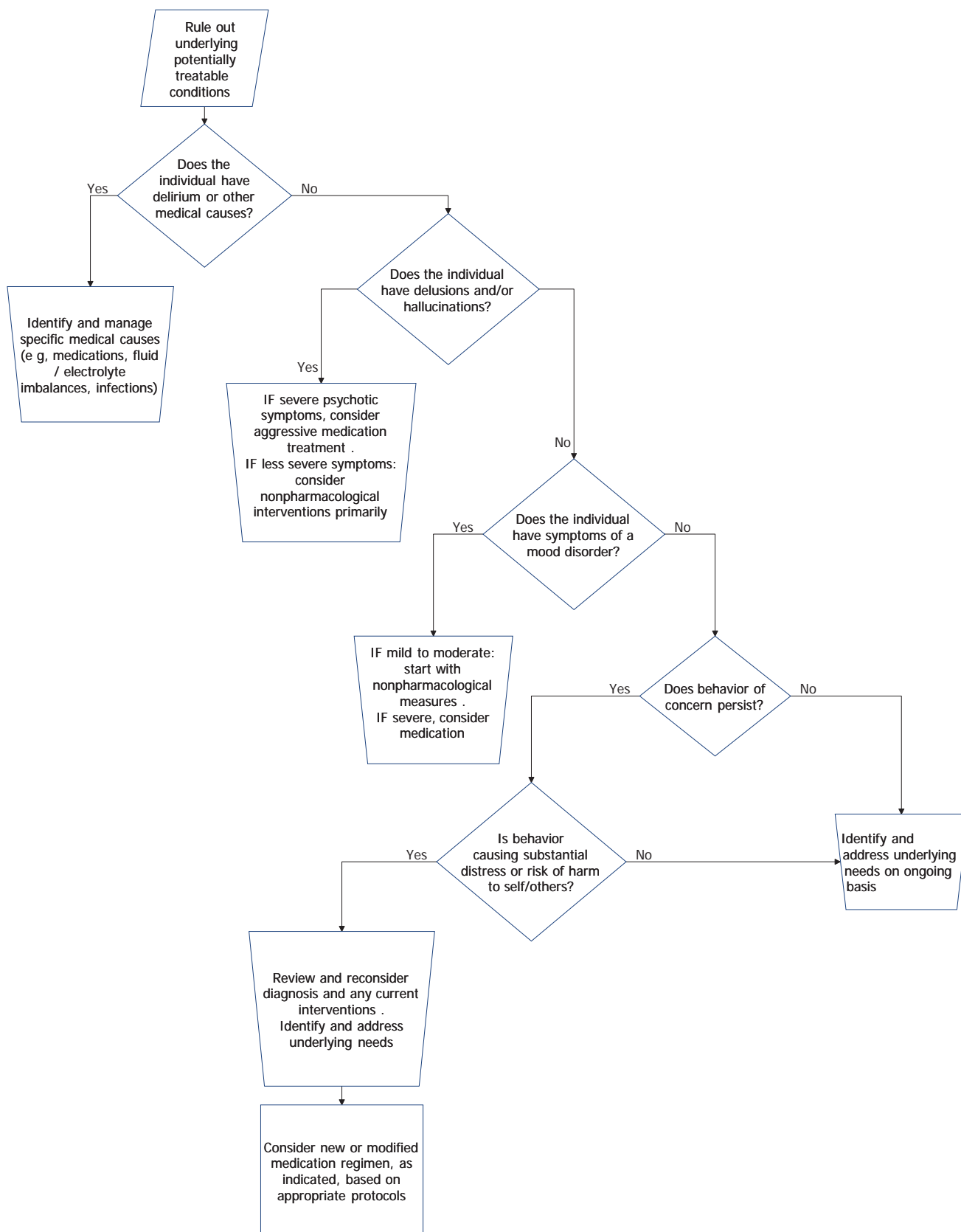
According to federal guidance, antipsychotics should not be used if the only indication for drug use is one or more of the following issues: wandering, poor self care, restlessness, impaired memory, anxiety, depression (without psychotic features), insomnia, unsociability, indifference to surroundings, fidgeting, nervousness, uncooperativeness, or agitated behaviors that do not represent a danger to the resident or others. CMS requires attempted gradual dose reductions of the antipsychotic and the use of behavioral interventions (unless clinically contraindicated).

In keeping with the Partnership to Improve Dementia Care, _____ Nursing Center is focusing on dementia care and reducing the use of antipsychotic medications, when possible, to address disruptive behaviors. We would like you to be aware of our effort and to support our clinical staff in managing behavioral issues with the limited use of antipsychotics and to consider gradual dose reductions or eliminate medication use for individuals without a history of psychiatric illness or current psychiatric symptoms.

We appreciate your support in helping us provide the best possible care to the individuals we serve. If you have any questions or need further information, please contact _____ (DON) at _____ (phone number).

We cannot achieve success without you!

Approach to Considering Causes of Behavior



GUIDANCE TO USING THE CONSIDERING CAUSES OF BEHAVIOR ALGORITHM

How to Use the Algorithm

This algorithm, entitled, “Approach to Consider Causes of Behavior,” is intended to provide a framework for thinking about medical and psychiatric conditions that cause or contribute to behavior, especially when:

- The situation is not simple (that is, something other than a straightforward intervention that readily corrects an identifiable cause).
- The causes are unclear.
- Interventions have been based mostly on conjecture.
- Behavior details or patterns are markedly different than baseline or anticipated.
- Behavior is accompanied by other symptoms, abnormalities or changes in condition, such as falling, loss of appetite, unstable vital signs, breathing difficulty, and change in level of consciousness.
- The individual is getting worse despite interventions, or initial or previous interventions are not working or not working as well as anticipated.

How to Do Cause identification

The algorithm focuses on cause identification. Cause identification is always preceded by recognition, description (organizing a story of what is happening) and assessment (gathering details). Effective cause identification (including, for doctors, diagnosis) depends heavily on the clarity and pertinence of information gathered by the nurse during assessment and the organization and completeness of the “story” of the situation.

The cause identification steps include:

- **Observe** and describe the situation in detail (what happened, in what sequence, who was involved, when, how often, how severe, etc.) and give the sequence of events before, during, and after the behavior occurred.
- **Gather** more details about the individual (past history, medications, environment, specific findings such as presence of hallucinations or paranoia, etc.).
- **Organize** the information.
- **Plan** by identifying appropriate interventions, based as much as possible on the thinking about likely causes.
- **Review** the information with a practitioner and discuss what the information leads to about possible or likely underlying causes.

When to Use the Algorithm

The algorithm is designed for nurses and practitioners. It can be used at a safety meeting/huddle or any interdisciplinary team meeting about the resident where the underlying causes of behavior are discussed.

For more direction on how to identify the causes of behavior, go to the [Case Study 1: Antipsychotic Drug issues](#).

OUTCOMES PLANNING

ANTIPSYCHOTIC MEDICATION TAPERING CHECKLIST

Tapering More Likely to Succeed If	Potential Problems If
<input type="checkbox"/> There is a clear and detailed picture of the individual's cognition, mood, and behavior, including accurate diagnoses and identification of underlying causes	<input type="checkbox"/> The picture of the individual's cognition, mood, and behavior are muddled, with vague descriptions, questionable or unconfirmed diagnoses, and unclear identification of underlying causes
<input type="checkbox"/> The individual does not have delirium or acute psychosis	<input type="checkbox"/> The individual has delirium or acute psychosis
<input type="checkbox"/> The individual was not recently ill or hospitalized with significant medical illness that has affected mood, behavior, cognition, or function	<input type="checkbox"/> The individual was recently ill or hospitalized with significant medical illness that has affected mood, behavior, cognition, or function
<input type="checkbox"/> Individual's behavior and mood have been stable for an extended period (weeks to months)	<input type="checkbox"/> Individual's behavior and mood have been unstable in recent weeks or only stable for several weeks
<input type="checkbox"/> The reason why an antipsychotic was started is clear, based on reliable information	<input type="checkbox"/> The reason why an antipsychotic was started is unclear and/or speculative
<input type="checkbox"/> The individual is not taking any other medications that can cause psychosis and/or adversely affect behavior or mood	<input type="checkbox"/> The individual is taking other medications (in any category, not just psychopharmacological medications) that can cause psychosis and/or adversely affect behavior or mood
<input type="checkbox"/> There are specific goals related to target symptoms and a pertinent approach to documenting, monitoring, and reporting those target symptoms	<input type="checkbox"/> There are no specific goals, or only vague ones, related to target symptoms and a pertinent approach to documenting, monitoring, and reporting those target symptoms
<input type="checkbox"/> A practitioner is available and willing to help staff reassess the individual's status during the period of medication tapering	<input type="checkbox"/> A practitioner is unavailable, unable, or unwilling to help staff reassess the individual's status during the period of medication tapering
<input type="checkbox"/> The individual (where feasible) and family (or other substitute decision maker) are involved in the plan for tapering medication and monitoring results	<input type="checkbox"/> The individual (where feasible) and family (or other substitute decision maker) are not involved in the plan for tapering medication and monitoring results
<input type="checkbox"/> Effective non-pharmacological interventions have been instituted	<input type="checkbox"/> Non-pharmacological interventions have not been successful in preventing or controlling symptoms
<input type="checkbox"/> Previous attempts at tapering psychopharmacological medications were successful, and symptoms have not recurred to any significant extent	<input type="checkbox"/> Previous attempts at tapering psychopharmacological medications were unsuccessful, and/or medications have had to be restarted previously or added, due to recurrence of significant symptoms

Using of the checklist:

1. Check off the applicable boxes for each of the 10 rows above.
2. Count the number of boxes checked in each column.
3. Tapering of an antipsychotic medication is more likely to succeed if substantially more items in the left-hand column are checked compared to the right-hand column.
4. To the extent possible, address the issues checked off in the right-hand column before or while attempting to taper an antipsychotic medication, in order to make successful tapering more likely.

IMPLEMENTATION

SBAR

Physician/NP/PA Communication and Progress Note

*To Discuss Possible Drug Reduction for an Individual
Already Receiving an Antipsychotic Drug for Off-Label Use*

Patient Name:

Date of Birth:

Medical record #:

Before Calling the MD/NP/PA:

- Evaluate the patient and complete the SBAR form
- Check VS: BP, pulse, respiratory rate, neurological check, lung sound, temperature, pain level
- Review chart for:
 - psychiatric conditions and/or hospitalizations
 - recent physician or psychologist progress notes
 - pharmacist medication regimen review notes
 - abnormal clinical and laboratory findings
 - notes on possible drug side-effects
- Be prepared to report on dosing changes, changes in target symptoms and potential side effects
- Have relevant information available when reporting (medication list including doses, method and time(s) of administration)
- Be prepared to have a list of all medications, including PRNs, and the individual's medical record

Situation

The drug and behavior (if problematic) I am calling about is _____

Date drug started ___/___/___

Date of last dose adjustment and dosage change made ___/___/___

Individual's symptoms has gotten worse/better/stayed the same since the drug started _____

Have any potential side effects been noticed? No Yes (If yes describe)

Things that make the symptoms worse

Things that make the symptoms better (non-pharmacological approach)

Other things that have occurred related to this symptom and treatment

Background

Primary diagnosis and/or reason person is at the nursing home

Pertinent mental health history

Behavioral concerns identified by family

Vital signs BP_____/_____/_____ HR_____/_____/_____ RR_____/_____/_____ Temp_____/_____/_____

Individual is on a scheduled pain management program Yes No

If yes, what medication interventions is the individual receiving?

Conditions (check all those that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> orthostatic hypotension | <input type="checkbox"/> drooling | <input type="checkbox"/> lip smacking/
chewing/abnormal tongue
movement |
| <input type="checkbox"/> weight gain | <input type="checkbox"/> tremors | <input type="checkbox"/> involuntary movement of
extremities |
| <input type="checkbox"/> increase glucose level | <input type="checkbox"/> rigidity | <input type="checkbox"/> worsening
confusion/delirium |
| <input type="checkbox"/> urinary retention | <input type="checkbox"/> slowness of movement | <input type="checkbox"/> fall |
| <input type="checkbox"/> constipation | <input type="checkbox"/> jerk body responses | |
| <input type="checkbox"/> sedation | <input type="checkbox"/> | |
| <input type="checkbox"/> restlessness | | |
| <input type="checkbox"/> pacing | | |

Other _____

Medication changes or new orders in the last two weeks _____

Recent Labs _____

Allergies _____

Any other data _____

Assessment (RN) or Appearance (LPN)

(For RNs): The individual's symptoms appear (better/worse/same) _____

I think the symptoms may be related to _____

Do you believe the individual has achieved a therapeutic dose? ___ No ___ Yes If yes: Do you believe dose reduction may be needed? _____

(For LPNs): The individual's symptom(s) appear (better/worse/same) _____

Request

I suggest or request (check all that applies):

- Other (start/change non-pharmacological approach)
- Change in/stop current med order(s)
- Provider visit (MD/NP/PA)
- Continued monitoring
- Lab work

Staff name _____ RN/LPN _____

Reported to: Name _____ (MD/NP/PA)

Date ___/___/___ Time ___AM/PM

If to MD/NP/PA, communicated via: _____

Phone (____) ____ - ____ In-person ____

Progress Note (complete and place SBAR/progress note in medical record)

___ Family or health care proxy notified
 Return call/new orders from MD/NP/PA Date ___/___/___ Time ___/___AM/PM

Signature _____ RN/LPN Date ___/___/___ Time ___/___AM

WHAT IS CHAT?

CHAT stands for **C**ommunicating **H**ealth **A**ssessments by **T**elephone. It is a quality improvement program to enhance telephone communication between the nurse and the physician.

The quality improvement program was developed by Heather Whitson, MD, S. Nicole Hastings, MD, Deborah Lakan, RNC, MSN, Richard Sloane, MPH, Heidi White, MS and Eleanor McConnell, RN, PhD from the Department of Medicine and the Center for the Study of Aging and Human Development and School of Nursing at Duke University, Durham, NC. The program was studied and conducted at Extended Care and Rehabilitation Center, Durham Veterans Affairs Medical Center. Funding support was provided by the AMDA Foundation and the John A. Hartford Foundation.

The purpose of the study program was to improve the communication of health assessment by telephone and determine whether satisfaction of on-site nurses improved after the **CHAT** intervention.

CHATs are point-of-care decision support tools adapted from the 2004 American Medical Director's Association (AMDA) protocols. They represent 16 common clinical problems found in long term care settings. The common conditions include:

Abdominal Pain	Agitation
Confusion	Altered Mental Status
Blood pressure	Low Blood Pressure
Chest pain	Constipation
Diarrhea	Dizziness/Unsteadiness
Dyspnea/Shortness of Breath	Fall
Fever	Hyperglycemia
Hypoglycemia	Musculoskeletal Complaint
Nausea or Vomiting	Urinary Complaints or Positive urinalysis

Each **CHAT** is designed to identify pertinent information that needs to be assessed and communicated for the specific clinical issue. The tools focus on the questions needing to be answered and the examinations needing to be conducted before calling the physician.

Patient Name: _____
Date of Birth: _____
Medicaid Record Number: _____

CHAT: AGITATION/CONFUSION/ALTERED MENTAL STATUS

History

How long ago did the symptoms start? Tell the story: _____

Other symptoms or events in the last 24 hours:

- Fall
- Constipation
- Medication changes
- Cough
- Fever
- Pain
- Urinary symptoms

Exam

Current vital sign _____
Oxygen saturation _____
Finger stick (blood glucose), if diabetic _____

Other pertinent information may include neurological assessment, signs of injury, dehydration or infection.

Staff Name: _____ RN/LPN

Reported to:

Name: _____ (MD/NP/PA) Date: _____ Time: _____ am ___ pm ___
If to MD/NP/PA, communicated via: _____ Phone _____ In person

(This CHAT has been modified by AHCA. The original CHAT is a product of Duke University)

Patient Name: _____

Date of Birth: _____

Medicaid Record Number: _____

CHAT: DIZZINESS/UNSTEADINESS

History

How long ago did this symptom start? Tell the story: _____

Has the patient had these symptoms on other occasions? Tell the story: _____

Any changes to the medication list or doses in the last week? _____

If yes, what medication changed? _____

Any PRN medication doses given in the last 24 hours?

If yes, what medication? _____

Exam

Blood pressure and pulse (sitting and standing): _____ and _____

Finger stick (blood sugar), if diabetic: _____

Other pertinent information may include a neurologic exam and assessment of mental status.

Staff Name: _____

Reported to:

Name: _____ (MD/NP/PA) Date: _____ Time: _____ am ___pm ___

If to MD/NP/PA, communicated via: _____ Phone _____ In person _____

(This CHAT has been modified by AHCA. The original CHAT is a product of Duke University.)

Patient Name: _____
Date of Birth: _____
Medicaid Record Number: _____

CHAT: FALL

History

Is the patient having new pain anywhere since the fall? Tell the story: _____

Did the patient hit his/her head? Tell the story: _____

Any loss of consciousness before or after the fall? Tell the story: _____

Exam

Can the patient ambulate as well as he/she could before the fall? _____

Any obvious injuries (lacerations, deformities)? _____

Blood pressure and pulse (sitting and standing) _____

Other pertinent information may include joint assessment for range of motion, assessment of mental status (level of consciousness, orientation, speech), blood glucose if patient is diabetic.

Staff Name: _____ (RN/LPN) _____

Reported to:

Name: _____ (MD/NP/PA) Date: _____ Time: _____ am ___ pm ___

If to MD/NP/PA, communicated via: _____ Phone _____ In person

(This CHAT has been modified by AHCA. The original CHAT is a product of Duke University.)

EVALUATION

ANTIPSYCHOTIC MEDICATIONS QA REVIEW TOOL

The Antipsychotic Medications QA Review Tool is intended to be used by centers to help evaluate prescribing and gradual dose reduction decision making practices. The tool is structured to follow nursing process and should be used to evaluate adherence to process with regard to treatment and care plan decisions involving medication use, reduction or discontinuation. Evaluate question responses to determine practice improvement areas.

	YES	NO	N/A
RECOGNITION			
1. Is there documentation of the details of any potentially problematic behavioral responses?			
2. Is there a clearly documented rationale for why a behavioral response is considered problematic?			
3. Is there documentation of a careful review of the medication regimen, including review for medications that impact behavior, mood, and cognition?			
CAUSE IDENTIFICATION			
4. Is there documented effort to review underlying medical and nonmedical causes of problematic behavioral responses, beyond attributing them to dementia or sundowning?			
5. Did you ask the resident and/or the family directly about a possible cause/trigger of their behavior?			
6. Are direct caregivers consulted about possible cause/trigger of behavior?			
MANAGEMENT			
7. Are there specific goals and objectives for responding to a resident's behavioral expressions?			
8. Is there a documented rationale for choosing and implementing specific interventions, including non-pharmacological approaches?			
9. Is there a documented rationale for initiating or continuing to use any medications in any category that can affect mood, cognition, level of consciousness, or behavior?			
10. Is the resident and family involved in the decision to stop or continue medication and other care plan decisions?			
MONITORING			
11. Is there evidence of ongoing monitoring/documentation of an individual's responses to interventions and related adjustment of interventions?			
12. Is there evidence of ongoing monitoring/documentation for complications of any interventions and for addressing the causes of such complications?			
13. Is there a documented rationale, included in the care plan, for initiating, continuing, or modifying any interventions, including antipsychotics?			

ASSESSMENT OF RESIDENT RECEIVING PSYCHOTROPIC MEDICATION

The goal of this assessment is to review residents who are receiving psychopharmacological medications. The tool can be used to guide discussion in reviewing resident behavior during Risk or Care Management and/or Standards of Care Committee meeting where appropriate interdisciplinary members are in attendance, for example, Pharmacy Consultant, Medical Director, Behavioral Health Specialists, etc.

Use this tool for all residents admitted on psychotropic drugs and periodically after the medication has been started and/or severity of symptoms noted.

Resident Name: _____

Date of Admission: _____ Date of initial medication assessment: _____

Previous living arrangements prior to admission (check appropriate selection):

Home ___ AL ___ SNF ___ Other _____

BIMs Score * _____ Date _____ or MMSE Score* _____ Date _____

List psychotropic drugs including antipsychotics, anxiolytics, sedative/hypnotics, antidepressants, and other drugs used to treat psychiatric/behavioral disorders or symptoms

Drug Name/Dose	Directions	Diagnosis/Indication	Start Date (If known)	Effective/Side Effects

Behaviors that prompted initiation of above medications; if not known, describe behaviors observed since admission: _____

Discussion at meeting is focused on effectiveness and relevance of continuing the medication. Also consider potential benefits of tapering and/or a trial off of psychotropic drugs, especially of antipsychotics and hypnotics. The following questions may prompt discussion.

- Have non-drug interventions been attempted in the past? If so, what have been the results and what interventions have been used?
- Has pain been assessed and managed?
- What are the possible needs the resident may be trying to communicate behaviorally?
- Are behaviors causing negative outcomes/ disturbing for the resident?
- Could behaviors be addressed by staff intervention instead of medication?

- Could behaviors be addressed by staff intervention instead of medication?
- Can these interventions be implemented routinely? If not, what are the barriers?
- Have medical causes been addressed? (i.e. metabolic and endocrine disorders, infections. etc.)
- Is staff response contributing to or increasing behaviors?
- Are families concerned about behaviors typically found in AD?
- Are family interactions with resident contributing to or increasing behaviors?
- Previous successes or failures with medications?
- Is the resident experiencing side effects from the medications? Are there other medications that might be contributing to behaviors?

Would a tapering or trial off antipsychotic or hypnotic meds be appropriate at this time?

If so, why? If not, why not? _____

Note: If a tapering or trial off is implemented, monitor carefully using behavior monitoring sheets.

Summary of discussion: _____

Recommendation(s) and Action Plan: _____

Identify team members completing this assessment: _____, _____,

_____, _____, _____, _____.

Date of follow up assessment: _____

Summary of behaviors since changes implemented: _____

Further recommendation(s) and Action Plan: _____

Identify team members completing this assessment: _____, _____,

_____, _____, _____, _____.

* MMSE – Mini Mental State Exam BIMs – Brief Interview of Mental Status

STAFF EDUCATION

ANTIPSYCHOTIC DRUGS – COMMON TERMS & DEFINITIONS

Atypical Antipsychotic (Second Generation) – Is a newer class of antipsychotic medication approved by the U.S. Food and Drug Administration (FDA) primarily for the treatment of schizophrenia and bipolar disorder.

There are currently 9 FDA-approved atypical antipsychotic drugs including:

1. Aripiprazole (Abilify) – Schizophrenia, Bipolar, and as added therapy for major depressive disorder
2. Asenapine (Saphris) – Schizophrenia and bipolar disorder
3. Clozapine (Clozaril) – Schizophrenia (restricted distribution)
4. Iloperidone (Fanapt) – Schizophrenia
5. Olanzapine (Zyprexa) – Schizophrenia, Bipolar, and as added therapy for treatment-resistant major depressive disorder
6. Paliperidone (Invega)– Schizophrenia and schizoaffective disorder
7. Quetiapine (Seroquel) – Schizophrenia, Bipolar, and as added therapy for major depressive disorder (Seroquel-XR)
8. Risperidone (Risperdal) – Schizophrenia and Bipolar
9. Ziprasidone (Geodon) – Schizophrenia and Bipolar

Behavioral Interventions are individualized non-pharmacological approaches (including direct care and activities) that are provided as part of a supportive physical and psychosocial environment, and are directed toward preventing, relieving, and/or accommodating a resident's distressed behavior.

Black Box Warning refers to the FDA warning to communicate the risks associated with increased mortality in elderly patients with dementia-related psychosis treated with antipsychotic drugs.

WARNING

Increased Mortality in Elderly Patients with Dementia-Related Psychosis — Elderly patients with dementia-related psychosis treated with atypical antipsychotic drugs are at an increased risk of death compared to placebo. Analyses of seventeen placebo-controlled trials (modal duration of 10 weeks) in these patients revealed a risk of death in the drug-treated patients of between 1.6 to 1.7 times that seen in placebo-treated patients. Over the course of a typical 10-week controlled trial, the rate of death in drug-treated patients was about 4.5%, compared to a rate of about 2.6% in the placebo group. Although the causes of death were varied, most of the deaths appeared to be either cardiovascular (e.g., heart failure, sudden death) or infectious (e.g., pneumonia) in nature. [this drug] is not approved for the treatment of patients with dementia-related psychosis.

Environmental Causes of Behavior are situations or factors external to the individual that may cause or contribute to exacerbations of behavior and psychiatric symptoms; for example, level/type of stimulation, noise, confusion, lighting, caregiver approach, institutional routines/expectations, and lack of cues.

Extrapyramidal symptoms (EPS) are neurological side effects of medications (including, but not limited to, antipsychotic medications) that result from an imbalance of the extrapyramidal nervous system. EPS includes various syndromes such as:

- Akathisia, which refers to a distressing feeling of internal restlessness that may appear as constant motion, the inability to sit still, fidgeting, pacing or rocking.
- Pseudoparkinsonism is a syndrome of Parkinson-like symptoms including tremors, shuffling gait, slowness of movement, expressionless face, drooling, postural unsteadiness and rigidity of muscles in the limbs, neck and trunk.
- Dystonia, which refers to an acute, painful, spastic contraction of muscle groups (commonly the neck, eyes and trunk) that often occurs soon after initiating treatment and is more common in younger individuals.

Gradual Dose Reduction (GDR) is the stepwise tapering of a dose of medication to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued.

Off-Label use of Antipsychotic Antipsychotic drug used for indications other than those that are approved by the FDA.

Psychiatric Causes of Behavior are commonly recognized disorders (e.g., depression, delirium, psychosis, personality disorders) that appear to cause or contribute to behavior and related symptoms.

Psychoactive Medication (or Psychotropic Medication) is a chemical substance that crosses the blood-brain barrier and acts primarily upon the central nervous system where it affects brain function, resulting in changes in perception, mood, consciousness, cognition and behavior.

Typical Antipsychotic (First Generation Antipsychotics, Neuroleptics, or Major Tranquillizers) refers to the original group of medications that were first used successfully to treat primary psychotic disorders such as schizophrenia. Common First Generation drugs include Compazine, Haldol, Loxitane, Mellaril, Moban, Navane, Orap, Prolixin, Stelazine, Thorazine, and Trilafon.

Unmet Physical Needs are basic human physical conditions or needs that have yet to be satisfied, for example; pain, illness, hunger, sleep disturbance, constipation, elimination needs. {NOTE: Medication is not a physical need; it is a treatment for physical or other needs.}

Unmet Psychological Needs are imbalances related to basic human emotions, for example; loneliness, boredom, apprehension, worry, fear, lack of socialization, loss of intimacy.

CASE STUDY 1: BEHAVIOR ISSUES IN A RESIDENT WHO IS ALREADY RECEIVING PSYCHOPHARMACOLOGICAL MEDICATIONS

The Story - Part 1

The Patient: Mr. Donald Lee, born in February 1925, admitted to the facility in September 2011.

Problem Statement: Donald is an 87-year-old male with advanced dementia who has been a resident in the facility for 5 months. Until recent weeks, he had been relatively stable. In the past few weeks, His behavior issues have become more frequent, problematic and unpredictable. He had become increasingly restless and combative over several weeks. Sleep was very poor with continuing restlessness throughout the night. He has had a colostomy for several years. Recently, he had begun pulling on and dislodging his colostomy. He has become increasingly combative and restless, with a shorter than usual attention span. Repeated efforts to redirect his behavior failed. He talks incessantly and despite being asked repeatedly about personal needs, his responses were not relevant. He has a very short attention span. Staff was unable to keep him engaged in any activities.

“The Story” – Background:

- Donald was admitted to the facility immediately after hospitalization due to a fall down steps at home that caused a subdural hematoma.
- Admission diagnoses included cerebellar mass, subdural hematoma, dementia, dysphagia, atrial fibrillation, peripheral vascular disease, hypertension, COPD, hypothyroidism, polymyalgia rheumatica, glaucoma, history of resected rectal carcinoma with colostomy and depression.
- Donald had lived at home with his wife, who comes and visits him daily. He has a daughter who is very involved in his care.
- During his working days, Donald was a Marine. He has been retired for many years. He was a smoker and has significant chronic obstructive pulmonary disease (COPD) and heart disease.

Medications and Outcomes:

- On admission to the facility, his key medications included Sertraline 25 mg hs for mood disorder, Levothyroxine 0.050 mg qd for hypothyroidism, Namenda 10 mg qd for dementia, Prednisone 10 mg qd for COPD, Digoxin 0.125 mg qd for atrial fibrillation, and Tramadol 25 mg q8h PRN for pain.
- Namenda was subsequently increased some time after admission to b.i.d. Olanzapine 2.5 mg qd PRN was added for severe agitation. Melatonin 2 mg hs was added to help with sleep.
- On 4/1/12, Olanzapine 2.5 mg qd PRN was discontinued. There was no improvement noted.
- On 4/2/12, Sertraline was changed to every other day. No improvement was noted.
- On 4/19/12, Melatonin was increased from 2 to 3 mg hs. No improvement in his sleep was noted.
- On 4/23/12, Risperdal 0.25 mg was ordered for 3 days. A psychiatric consultation was requested.
- On 4/30/12, the psychiatrist recommended discontinuing Melatonin and Zolof and starting Risperdal 0.25 mg qhs for possible dementia with mania. No improvement was noted.
- On 5/1/12, a Digoxin level was within the therapeutic range. Donald was restless and up much of the night.
- On 5/2/12, Trazodone 25 mg qhs was ordered with no improvement in sleep noted.
- On 5/7/12, staff noted an acute change in mental status and found Donald difficult to arouse.

Teaching: Part 1

Communicating with the Attending Physician about the Resident's Change in Condition

Have nurses review the background information for Donald Lee and then instruct them to respond to the questions below.¹

1. What information is least relevant to have in preparation for the call?
 - a. Resident history of advanced dementia
 - b. He has a history of COPD
 - c. Increasing incidents of restlessness and problem behavior
 - d. Recent history of dislodging his colostomy
2. When using the SBAR communication technique, the nurse's initial statement to the physician should be?
 - a. I'm sorry to bother you about the resident
 - b. One of your residents seems to have a problem
 - c. Resident has a history of dislodging his colostomy
 - d. I'm concerned about Mr. Lee, he has an acute change in mental status and is difficult to arouse
3. In this situation, what patient data should be reported first?
 - a. Details of the current mental status change
 - b. Admission diagnoses
 - c. Outcomes of medication changes
 - d. Psychiatric consultation recommendations
4. Before discussing subsequent treatment or testing with the physician, the nurse should be prepared to
 - a. Discuss potential causes of the acute change in mental status
 - b. Review the resident's story in chronological order
 - c. Review the current medication regimen
 - d. All of the above

Answers

1. B – The resident's COPD history is not immediately relevant to this situation. A list of diagnoses is not nearly as helpful as a clear and concise description of current mental status, including behavior, mood, and cognition.
2. D – The first part of the SBAR is to clearly and concisely describe the situation. Giving the resident's name, a clear and meaningful statement of the clinical problem and the nurse's concern, alerts the physician to the problem.
3. A – Since the change in mental status is the primary current issue, this information should be presented first and will then set the foundation for offering and evaluating additional pertinent information.
4. D – The nurse's communication with the physician, regardless of clinical problem, should always give enough information so that the practitioner can begin to think about possible causes of the symptom or problem, in order to identify, to the extent possible, parameters for monitoring and the need for possible diagnostic testing, follow-up, and changes in treatment. It is important to

¹ Questions adapted from NURSE.com, Nursing Spectrum (DC/Maryland/Virginia), Clinical Vignette, June 18, 2012, page 31.

give the practitioner time to think through the situation in order to do more than just guess about what is going on or what to do next.

Continuing Case of Donald Lee

- On 5/7/12, Donald was transferred to the hospital Emergency Room. Lab and diagnostic tests that were done in the hospital were unremarkable. The resident was returned to the facility without hospitalization.
- On 5/8/12, Trazodone was discontinued and Namenda was reduced from b.i.d. to daily.
- On 5/9/12, Risperdal was discontinued.

The Story – Part 2

How to Apply Critical Thinking/Reasoning to Determine Problem Cause:

Every discipline can contribute to cause identification, by following an appropriate process. When done by a health care practitioner, cause identification is referred to as “diagnosis.” Nurses and those of other disciplines can help practitioners by providing enough of the right information to allow thoughtful diagnostic decision making. Every discipline, including nursing, can potentially apply the same thoughtful approaches to improve other cause identification activities.

Once the nurses/interdisciplinary team have completed the “Communicating with the Physician about the Resident’s Change in Condition” questions section, and have identified and discussed the correct answers, have the group focus on their **Critical Thinking/Reasoning** in trying to understand the cause of the resident’s issues. Critical Thinking/Reasoning can be accomplished by asking basic questions about the resident to distinguish between potential causes of the problem.

Clinical Thinking/Reasoning Question for Donald Lee

1. Could Mr. Lee have a medical cause of his behavior?
 - Could he be hypothyroid? He was taking a relatively low dose of thyroid replacement. His TSH on 9/19/11 was WNL (3.06). A repeat TSH on 3/23/12 was also WNL. Probability of hypothyroidism as a cause: **very low**.
 - Could he have an infection or heart failure? Chest X-ray 9/30/11 had shown small bilateral infiltrates and an L pleural effusion. In early 2/12, he had been hospitalized with pneumonia. However, there was no current clinical evidence of infections and lab tests were negative. Breathing and vital signs were unchanged. Probability of infectious or cardiac cause: **unlikely**.
 - Could Donald have delirium? The resident had a shortened attention span, frequent fluctuation in behavior and level of consciousness, increased level of involuntary motor activity (restlessness), and altered sleep cycle. All of these findings are consistent with delirium. Possibility of delirium: **high**.
 - Could Donald have some other contributing medical problem? He was not anemic. Despite his COPD, he was not hypoxic enough to account for these symptoms. Also, behavior issues fluctuated regardless of oxygen levels. Possibility of hypoxia: **unlikely**.
2. Could Mr. Lee have a medication cause for his behavior?
 - Could he have digoxin toxicity? Digoxin toxicity can cause various psychiatric symptoms. However, the serum digoxin level was in the middle of the therapeutic range. Probability of Digoxin toxicity: **very low**.
 - Could he have other medication-related adverse consequences? Prednisone can cause psychosis and other behavioral and mood changes. However, his dose was about equal to what the body produces

normally, and the dose had remained constant for years. Probability of prednisone-related cause: **very low**.

- Could he have side effects from his psychopharmacological medications? Sertraline had been continued under the presumption that the resident had a diagnosis of depression. However, it was not clear why or when this was started. There was no clear evidence that he had a mood disorder. Any psychopharmacological medications, including antidepressants and antipsychotic medications, can potentially exacerbate behavior and psychiatric symptoms. In this case, they were not helping improve the symptoms. His behavior was getting worse. Possibility of adverse effects from existing medication regimen: **likely**.

3. Could Mr. Lee have a psychiatric basis for his behavior?

- Could Donald have psychosis? He could have psychosis, although the condition was fluctuating more than it was escalating steadily. Hallucinations, delusions, and paranoia were noticeably absent. Antipsychotic medications did not result in symptom improvement. Possibility of psychosis: **low**.
- Could he have a mood disorder? He was already receiving an antidepressant, despite lack of evidence for a mood disorder. His symptoms represented more than simple anxiety. Possibility of mood disorder: **unlikely**.
- Could he have a personality disorder? There was no evidence of a personality disorder during his earlier years, and the symptoms were not compatible with that. Possibility of personality disorder: **unlikely**.
- Could he have simple dementia-related symptoms? The determination of dementia-related symptoms is reached by first ruling out other possible causes. In this case, other likely causes were identified. Possibility that this was simply related to dementia: **unlikely**.

4. Could Mr. Lee have a psychosocial or environmental cause for his behavior?

- Could Mr. Lee have unmet personal needs causing his behavior? Between staff and family, his needs had been addressed consistently since admission. His worsening behavior was ongoing regardless of his personal needs being met. When asked about personal needs and comfort, Mr. Lee's responses were not coherent or relevant. Possibility of unmet personal needs: **unlikely**.
- Could he have environmental causes? His environment had not changed since admission. Throughout his stay, multiple psychosocial interventions were implemented without success. Symptoms persisted and were not correlated with the presence or absence of such interventions. Nothing was working. Effort to redirect behavior failed. Possibility of environmental factors: **unlikely**.
- Was he indicating that he did not want the colostomy by trying to remove it? From the time of admission until his recent episodes started, he had never expressed or shown discomfort with the colostomy previously. It had never caused him any complications. The pulling on the colostomy was not an isolated activity, but was associated with increasing restlessness and uncontrolled motor activity. He seemed unaware about what he had done. Possibility of behavior relating to not wanting his colostomy: **unlikely**.

Outcome of Critical Thinking/Reasoning

Based on the above critical thinking questions, the answers indicating **Yes/Likely** help narrow down the thinking about likely causes of the behavior. These outcomes include:

- Primary: He has delirium and side effects from psychopharmacological medications
- Secondary: He has a baseline of chronic, dementia-related behavior

The reporting nurse gives the practitioner enough information to engage in a meaningful conversation about these potential causes. Before and after the specific incident that is reported, the entire staff works with the

practitioner to identify next steps (medication changes, monitoring, etc.) to test these hypotheses about causes.

The Subsequent Story of Donald Lee

After stopping his Sertraline and Trazodone and reducing the Namenda dose, there was a remarkable and rapid improvement. Donald became calmer, stopped pulling on his colostomy, slept much better at night, was easily directable, sat out in the hallway with his family, attended some activities, and was generally pleasant and responsive. He has remained stable for several months. However, he was just as confused and disoriented as before.

Teaching: Section 2

How to Apply Critical Thinking/Reasoning to Determine Problem Cause:

- When teaching a group of caregivers, consider using a **Learning-Circle*** approach. Ask clinicians to frame a question (**Could the resident have ...**) and repeat the exercise until all possible questions are identified. Keep a list of the questions.
- Once all the questions are put forth, consolidate them by eliminating redundancies. It will be helpful to categorize question based on possible **Medical Causes, Medication Causes, Psychiatric Causes, and Psychosocial/Environmental Causes.**
- Discuss the answers to the questions and ask clinicians to identify and help staff understand the reasoning behind answers to the various possibilities, including Yes/Likely, Unlikely/No, and Probability High, Probability Low
- From the critical thinking exercise, have clinicians develop the key clinical assumption(s) and develop a SBAR in preparation for reporting to the physician on this case.
- Have clinicians use this approach in reporting to the physician in other cases (not just behavior or psychiatric issues).

***Learning Circle Resources**

<http://www.pioneernetwork.net/Data/Documents/LearningCircleKeane.PDF>

<http://www.learn.org/circles/lcguide/> A teachers' guide to cross-classroom collaboration on projects integrated with curriculum.

AHCA'S SUGGESTED TOOLS FOR REDUCING OFF-LABEL USE OF ANTIPSYCHOTICS:

How These Tools Can Improve Regulatory Compliance

AHCA suggests a number of tools that can be used in a facility to assist in the reduction of off-label use of antipsychotics. To help achieve compliance with some regulatory requirements that relate to the off-label use and reduction of antipsychotics, the ideal is to use all of these tools or tools with similar components. By using them effectively, a facility may not only reduce the off-label use of antipsychotics but may also receive improved regulatory compliance related to their use.

“Clinical Guideline: Managing Behaviors Expressed by Residents with Dementia” directs the nurse to assess and evaluate a resident using the SBAR algorithm. The review must include, at a minimum, seven specified areas. Communication with professionals as well as with the patient and the patient’s family are important elements of this Guideline.

The SBAR is a communication tool that assists a nurse effectively convey to a physician the assessment process that has been used to reach certain conclusions and recommendations. This tool may be used when a patient has experienced a significant change and when the nurse would like to discuss a different approach for the care of a patient.

Antipsychotic Medication Tapering Checklist provides a systematic way to determine the likely success of tapering an antipsychotic. When completed and added to a patient’s medical record, this provides strong support for the decisions made related to each patient and implementing a tapering regimen.

Both the Antipsychotic Medications QA Review Tool and the Assessment of Psychotropic Medications will provide necessary information and guide discussion and decision-making related to the use of psychotropic medications for individual patients. This can be done within or independent of the QA&A process.

Taken in total, these tools will assist a facility to be in compliance with the following F-Tags:

F157 – Notification of Changes

F154, F155 – Notice of Rights and Services

F272, F273, F274, F275, F276, F278 – All related to assessments, reassessments, or coordination of assessments

F279 – Comprehensive Assessments

F281 – Professional Standards of Care

F309 – Pain Management

F329 – Unnecessary Medications

F281 – Professional Standards

F428 – Medication Regimen Review

F520 – Quality Assessment and Assurance